GOVERNMENT OF KERALA

Abstract

Health and Family Welfare Department – National Rural Health Mission - Accredited Social Health Activists (ASHA) – Guidelines for implementation – ORDERS ISSUED

HEALTH AND FAMILY WELFARE DEPARTMENT

G.O. (Rt) No: 649/07/H&FWD Dated, Thiruvanathapuram 24th February 2007

Read: Accredited Social Health Activists (ASHA) Guidelines from Ministry of Health and Family Welfare, Government of India

The ASHA (Accredited Social Health Activist) scheme, which is a key intervention planned as part of National Rural Health Mission was earlier planned to be implemented in the States with poor Health Indicators. It was later noted that even in States where the Health indicators are good, like in Kerala, there are some vulnerable pockets where the indicators are very poor compared to the State average. Under the National Rural Health Mission (NRHM), Ministry of Health and Family Welfare Govt. of India provides financial assistance, through the State Health and Family Welfare Society, to appoint Accredited Social Health Activists (ASHA) in areas with tribal population in the State. The Govt. of India, through the RCH Programme also provides funds for appointment of Link workers in coastal areas and urban slums. These are voluntary workers who will be compensated for the time they spent through performance linked incentives. They are expected to act as links between the existing Health Care system and the disadvantaged groups in tribal areas, coastal areas and urban slums. The Govt. of India has also permitted the State to evolve guidelines for the implementation of the scheme in the State depending on the requirements of the State. The State Mission Director (NRHM) has forwarded draft guidelines in consultation with DHS, the Government of India guidelines suitably modified to the requirements of the State, for the implementation of the ASHA / Link worker Scheme in the State.

The Government has examined the matter in detail and is pleased to accord approval for the schemes in Kerala, as per guidelines detailed in the Annexure I. The State Mission Director

will transfer funds to the districts for implementation of the activity, based on allocations received from Ministry of Health & Family Welfare in consultation with Government.

The State Mission Director (NRHM) has also forwarded a list of officers who are to be placed in charge of the implementation of the Scheme in the State. The Government have examined the matter in detail and are pleased to accord approval for the appointment of Dr. C. K. Jagadeesan, Research Officer, Director of Health Services as the State Nodal Officer for the ASHA programme and Dr. V. Jithesh, District Programme Manager, NRHM, Wayanad & Ms.Seena K.M Consultant (Social Development), NRHM as the Asst. State Nodal Officers.

By the order of the Governor

Dr.Vishwas Mehta,
Secretary to Government

To
State Mission Director (NRHM)
Director of Health Services
Director of Tribal Welfare
Director, Social Welfare Department
Director, Medical Education
Director, PRD
Concerned District Collectors
Concerned Mayors, Corporations
Concerned Chairpersons, Municipalities
Concerned Presidents, PRIs
SPS to Minister (Health)
Secretary LSG (with C/L)
Secretary (Health)

Forwarded/By Order

Section Officer

Annexure I

GUIDELINES FOR ACREDITED SOCIAL HEALTH ACTIVIST (ASHA) SCHEME

Background

The Government of India has decided to launch a National Rural Health Mission (NRHM) to address the health needs of rural population, especially the vulnerable sections of society. The Sub-centre is the most peripheral level of contact with the community under the public health infrastructure.

Currently Anganwadi Workers (AWWs) under the Integrated Child Development Scheme (ICDS) are engaged in organising supplementary nutrition programmes and other supportive activities. The very nature of her job responsibilities (with emphasis on supplementary feeding and pre school education) does not allow her to take up the responsibility of a change agent on health in a village. Therefore, a new band of community based functionaries, named as Accredited Social Health Activist (ASHA) – for tribal areas, coastal areas & urban slums, is proposed to fill this void. The ASHA for tribal areas will be funded from the NRHM & those for coastal areas and urban slums shall be funded from RCH.

ASHA will be the first port of call for any health related demands of deprived sections of the population, especially women and children, who find it difficult to access health services. In following pages, the role, responsibilities, profile, selection procedure, training modality and compensation package for ASHA has been explained.

Roles and responsibilities

ASHA will be a health activist in the community who will create awareness on health and its social determinants and mobilize the community towards local health planning and increased utilization and accountability of the existing health services. She would be a promoter of good health practices. She will also provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals. Her roles and responsibilities would be as follows:

- ASHA will take steps to create awareness and provide information to the community on determinants of health such as nutrition, basic sanitation& hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilization of health & family welfare services.
- She will counsel women on birth preparedness, importance of safe delivery, breastfeeding and complementary feeding, Immunisation, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infection (RTIs/STIs) and care of the young child.
- ASHA will mobilize the community and facilitate them in accessing health and health related services available at the Anganwadi/sub-center/primary health centers, such as

Immunisation, Ante Natal Check-up (ANC), Post Natal Check-up supplementary nutrition, sanitation and other services being provided by the government.

- She will work with the Village Health & Sanitation Committee of the Gram Panchayath to develop a comprehensive village health plan.
- She will arrange escort/accompany pregnant women & children requiring treatment/admission to the nearest pre-identified health facility i.e. Primary Health Centre/Community Health Centre/First Referral Unit (PHC/CHC/FRU).
- ASHA will provide primary medical care for minor ailments such as diarrhea, fevers, and first aid for minor injuries. She will be a provider of Directly Observed Treatment Short-course (DOTS) under Revised National Tuberculosis Control Programme.
- She will also act as a depot holder for essential provisions being made available to every habitation like Oral Rehydration Theraphy (ORS), Iron Folic Acid Tablet (IFA), Chloroquine, Oral Pills & Condoms, etc.
- She will inform about the births and deaths in her village and any unusual health problems/disease outbreaks in the community to the Sub-Centers/Primary Health Centre.
- She will promote construction of household toilets under Total Sanitation Campaign.
- Fulfillment of all these roles by ASHA is envisaged through continuous training and up-gradation of her skills, spread over two years or more.

Selection of ASHA

- The general norm will be one ASHA per 1000 population. In tribal areas and hilly areas, this may be relaxed suitably depending on the local need (for 700 – 1000 tribal population).
- The list of the wards in tribal, coastal areas and in urban slums where ASHA have to be selected may be prepared by the Secretary of the LSGI concerned and approved by the District Health and Family Welfare Society.
- It should ensured that at least 40 percent of the envisaged ASHAs in the State are selected and given induction training in the first year as per the norms given in the guidelines. Rest of the ASHAs can subsequently be selected and trained during second and third year.

Criteria for Selection

- ASHA must be primarily a woman resident of the village/Coastal areas/Urban Slums - Married/Widow/Divorced and preferably in the age group of 25 to 45 yrs.
- ASHA should have effective communication skills, leadership qualities and be able to reach out to the community. She should be a literate woman with formal education up to Eighth Std.
- Adequate representation from the disadvantaged population groups should be ensured to serve such groups better.
- Preference should be given, where possible, to voluntary workers working in the Health system, such as Mahila Swasth Sangh, depending on their past performance

Selection Process of ASHA

- Dist Health & Family Welfare Society (DH&FWS) will oversee the process
- The District Programme Manager would be the District Nodal Officer to facilitate the selection process and organizing the Training of Trainers and ASHA as per the guidelines of the scheme.
- The ASHA will be selected by a Committee consisting of Panchayath President / Chairperson of Municipality or Corporation, Ward Member / Councillor, Medical Officer and Junior Public Health Nurse (JPHN).

Institutional Arrangements

The success of ASHA scheme will depend on how well the scheme is implemented and monitored. It will also depend crucially on the motivational level of various functionaries and the quality of all the processes involved in implementing the scheme. It is therefore necessary that well defined and yet flexible and participatory institutional structures are put into place at all levels from state level to village level.

(a) At the village level it is recognized that ASHA cannot function without adequate institutional support. The women's committees (like Self Help Groups), Village Health & Sanitation Committee of the Gram Panchayath, peripheral health workers especially JPHN and Anganwadi workers, ASHA trainers and in-service periodic training would be major source of support to ASHA.

(b) At the Local Self Government (LSG) level, a Co-ordination Committee with the PHC Medical Officer as Convener and LSG President as Chairperson will ensure involvement of Panchayathi Raj Institutions and civil society and support of all related Departments. The Coordination Committee shall consist of Health Standing Committee Chairman, Health Inspector, Lady Health Inspector, Kudumbasree coordinator, MNGO/FNGO representatives and representatives of other line Departments.

(c) The LSG would lead the ASHA initiatives in four ways:
   i. The LSG President / Chairperson and members will facilitate the selection of ASHA though the process outlined earlier.
   ii. It is involved in supporting the ASHAs in their work and itself undertaking many health tasks through its statutory health committee. All ASHA will be involved in this Village Health & Sanitation Committee of the LSG as members.
   iii. It develops the village health plan in coordination with ASHA.
   iv. A part of the compensation/incentive would be provided by/routed through the LSG

Role and Integration with Anganwadi

Anganwadi Worker (AWW) will help ASHA in performing following activities:

- Organising Health Day once a month. On Health day, the women, adolescent girls and children from the village will be mobilized for orientation on health related issues such as importance of nutritious food, personal hygiene, care during pregnancy, importance of antenatal check up and institutional delivery, home remedies for minor ailment and importance of immunization etc. AWWs will inform JPHN to participate & guide in organising the Health Days at Anganwadi Centre (AWC).
- AWWs and JPHNs will act as resource persons for the training of ASHA.
- IEC (Information Education Communication) activity through display of posters, pictures, folk dances etc on these days can be undertaken to sensitise the beneficiaries on health related issues.
- AWWs will update the list of eligible couples and also the children less than one year of age in the village with the help of ASHA.
- ASHA will support the AWW in mobilizing pregnant and lactating women and infants for nutrition supplement. She would also take initiative for bringing the beneficiaries from the village on specific days of Immunisation, health checkups/health days etc, to the Anganwadi Centers.
- The ASHA in consultation with AWW can take up innovative activities in a manner culturally relevant to the local community to popularise the messages that she is intended to spread.

Role and Integration with JPHN

JPHN will help and guide ASHA in performing the following:

- She will hold weekly/fortnightly meeting with ASHA and discuss the activities undertaken during the week/fortnight. She will guide her in case ASHA had encountered any problem during the performance of her activity.
- AWWs and JPHNs will act as a resource persons for the training of ASHA
- JPHNS will inform ASHA regarding date and time of the outreach sessions and will also guide her for bringing the beneficiaries to the outreach session.
- JPHN will participate & guide in organising the Health Days at Anganwadi Centre (AWC).
- She will take help of ASHA in updating eligible couple register of the village concerned.
- She will utilise ASHA in motivating the pregnant women for coming to sub centre for initial checkups. She will also help JPHNs in bringing married couples to sub centers for adopting family planning.
- JPHN will guide ASHA in motivating pregnant women for taking full course of IFA Tables and TT Injections etc.
- JPHN will orient ASHA on the dose schedule and side affects of oral pills.
- JPHN will educate ASHA on danger signs of pregnancy and labour so that she can identify these timely and help the beneficiary in getting further treatment.

Working arrangements

ASHA will have her work organised in following manner. She will have a flexible work schedule and her work load would be limited to putting in only about two-three hours per day, on about four days per week, except during some mobilization programmes, special events and training programmes.

A. **At Anganwadi Centre**: She will be attending AWC on the day when Immunization/ANC sessions are being organized. At least once a month, she would organize health days for health IEC, rudimentary health checkup and advice including medicine and contraceptive dispensation.
B. **At Home:** She will be available at her home so as to work as depot holder for distribution of supplies to needy people or for any assistance required in terms of accompanying a woman to delivery care centre/FRU or RCH camp.

C. In the Community: She will organise/attend meetings of village women/health committees and other group meetings and attend Panchayath health committees. She will counsel and provide services to the families as per her defined role and responsibility.

Training Strategy

Capacity building of ASHA is critical in enhancing her effectiveness. It has been envisaged that training will help to equip her with necessary knowledge and skills resulting in achievement of scheme's objectives. Capacity building of ASHA has been seen as a continuous process

1. Induction Training

23 days spread over 12 months

- ❖ 7 days pre-deployment training
- ❖ 4 episodes of training of 4 days each spread over the remaining period.

2. Periodic Training

- ❖ 2 days training every alternate month.

- **On-the-job Training:** ASHAs needs to have on the job support after training. After induction training and during the later periodic training phase it is needed to provide on the job training to ASHAs in the field, so that they can get individual attention and support that is essential to begin and continue her work. JPHN while conducting outreach sessions in the villages will contact ASHA of the village and use the opportunity for continuing education. Block and District trainers will also be responsible for providing on going training & support in the field.

- **Training of Trainers:** A cascade model of training is proposed. At most peripheral level, Block trainers (who are the members of identified block training teams) would have to spend at least 7 days in acquiring the knowledge and skills for Training ASHAs. These trainers should be largely women and chosen by Nodal Officer. The Block Training Teams would be trained by a District Training Team. (Or Master trainers) who are in turn trained by the State Training Team.

- **Continuing Education and Skill Up gradation:** A resource agency in the District / State (preferably an NGO) will be identified by the State. The resource agency in collaboration with Open schools and other appropriate community health distance education schemes will develop relevant illustrated material to be mailed to ASHAs periodically for those who would opt continuing their education for an eventual certification.

- **Venue of Training:** The principle of choice of venue shall be that the venue should be close to their habitation & that the training group should not be more than 25 to 30.

Roles and Responsibilities

Role of State Nodal Officer for ASHA

- To designate District Nodal Officer for ASHA training
- Selection of districts for ASHA scheme
- Constitution of District Training Teams (DTT)
- Development of plan for orientation of DTT

Role of District Nodal Officer for ASHA

- Selection of blocks in the district for ASHA training
- Constitution of Block Training Teams in consultation with District Health & Family Welfare Society
- Development of work plan for BTT
- Coordinate and conduct training of Block Training Team as per training plan

Role of PHC Medical Officers/ Local Medical Officer

In a non PHC area one Medical Officer will be designated as Local Medical Officer for the charge of ASHA

- To inform the selected ASHAs regarding training dates and venue through JPHNs/ AWW/ NGOs
- Selection of training venue
- To organize training of ASHA as per training plan through block training team
- Post training follow up

Compensation to ASHA

- ASHA would be an **honorary volunteer** and would **not receive any salary or honorarium.** Her work would be so tailored that it does not interfere with her normal livelihood.
- ASHA will have no claims for employment in Government services or the society based on their honorary work

- However ASHA could be compensated for her time in the following situations:
  (a) For the duration of her training, she will be paid DA of Rs. 100 per day and traveling expenses at actuals. (100 per day x 7 days = 700/-)

(b) For participating in the periodic training, she will be paid DA at same rate. (100 per day x 4 days x 4 sessions = 1600)
(c) Wherever compensation has been provided for under different national programmes for undertaking specific health or other social sector programmes with measurable outputs, such tasks should be assigned to ASHA on priority. As DOTS provider she will be paid Rs 250 for each case that has completed DOTS under her care.
(d) ASHA will be paid Rs. 600 in rural areas and Rs. 200 in urban areas, under JSY for each institutional delivery she facilitates, provided she fulfills the criteria under JSY and she stays with the pregnant women in hospital. This package will include referral transport assistance for ASHA and expectant women to go to the nearest health centre, subject to the condition that ASHA is paid a minimum of Rs. 200.
(e) For Immunisation day ASHA can work as a Social mobiliser and she will be paid Rs. 100 per session if she mobilises at least 5 children to the session.
(f) For promoting sterilisation activities, an incentive will be paid Rs. 200 for each tubectomy case and Rs. 300 vasectomy case.
(g) Other than the above specific programmes, a number of key health related activities and service outcomes are aimed within a village (For example data base of all eligible children immunized, all newborns weighed, all pregnant women attended an antenatal clinic etc. The Ward Health & Sanitation Committee at the beginning of each year can fix up specific goals for ASHA for the year depending on the actual situation in the village. ASHA can be given a special reward (Fixed at the outset) for achieving these goals. The expenses for this can be met from untied funds of Rs.10, 000 at Sub centre.
(h) For promoting house hold toilets ASHA will be paid an incentive for setting up toilets in a dwelling where there is no toilet.
(i) Non-monetary incentive e.g. exposure visits, annual conventions etc can be considered.

Monitoring and Evaluation

The following indicators shall be used for monitoring performance of ASHA.

Outcome Indicators

(a) % of newborn who were weighed and families counseled;
(b) % of children with diarrhea who received ORS
(c) % of deliveries with skilled assistance
(d) % of institutional deliveries
(e) % of JSY claims made to ASHA
(f) % completely immunized in 12-23 months age group.
(g) % of unmet need for spacing contraception among BPL.

Impact Indicators

(a) IMR
(b) Child Malnutrition rates
(c) Number of cases of TB/leprosy cases detected as compared to previous year.

During bi-monthly meetings, JPHN/Ward Health and Sanitation Committee should get information from ASHAs regarding the progress made and consolidate the report and present the same to the PHC Medical Officer or the designated Medical Officer in urban and coastal areas.